Hospital for Special Care Foundation

We Rebuild Lives.

NURSING SCHOLARSHIP APPLICATION - 2017

Last 4 digits of Social Security # __ __ __ __

GENERAL INFORMATION

Hospital for Special Care (HSC) welcomes scholarship applications for **2017** from students pursuing initial degrees in nursing. Seven scholarships will be awarded to students enrolling/enrolled in an accredited college/university as full-time or part-time undergraduate students.

Applications for the scholarship must be **postmarked by April 8, 2017**. Applications postmarked after this date will not be considered. This application becomes complete and valid ONLY when applicants have returned all documentation indicated on the checklist.

SEVEN SCHOLARSHIPS WILL BE AWARDED, each valued as indicated below:

1. **THE RONA BOTWINICK and THE FLORENCE TIMURA NURSING SCHOLARSHIP - $3,000**
2. **THE RONA BOTWINICK NURSING SCHOLARSHIP - $3,000**
3. **THE FLORENCE TIMURA NURSING SCHOLARSHIP - $2,750**
4. **THE DR. MICHAEL TIMURA, III NURSING SCHOLARSHIP - $2,750**
5. **THE PAUL SUTULA NURSING SCHOLARSHIP - $2,500**
6. **THE ELIZABETH TIMURA GOLD STAR MOTHER NURSING SCHOLARSHIP - $2,500**
7. **THE JOHN TIMURA NURSING SCHOLARSHIP - $2,500**

ELIGIBILITY REQUIREMENTS:

- Applicants must reside in the Greater New Britain area.
  (New Britain, Berlin, Farmington, Plainville, Newington and Southington)
- Eligible applicants: those students enrolling/enrolled in an associate degree or baccalaureate degree programs.
- Minimum of a **2.75** grade-point average on a 4.0 scale.
- Former HSC scholarship recipients **may not reapply** for these scholarships.
- The applicant's name must appear ***only*** on the first page of the application. To ensure a fair evaluation process, members of the selection committee will **NOT** know the identity of the person submitting the application.

NOTIFICATION AND AWARDS

The recipients will be notified in June and the awards will be sent directly to the schools by September.

SUBMIT ALL MATERIALS TO:

Hospital for Special Care Foundation, Inc.
Attn. Maria Pietrantuono; Administration
2150 Corbin Avenue, New Britain, CT 06053

Applications MUST be postmarked by April 8, 2017.

For more information, please call 860.832.6257; or
Visit our website at http://hfsc.org/careers/HSC-Scholarship-Program to download an application.

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APPLICANT INFORMATION

This is the ONLY area of the application where your identifying information will appear. Any reference to your name or any relationship to the Hospital for Special Care Foundation, Inc. or the Center of Special Care, Inc. on subsequent pages will **disqualify** your application.

Name (first):_____ (middle):_____ (last): _____
Address (street): _____
City: _____ State:_____ Zip: _____

Telephone: _____ Date of Birth: _____

CHECKLIST

Before you return your application package, please verify that you have enclosed the following information.
Any incomplete applications will be disqualified.

❒Applicant information, page 2

❒Academic profile, page 3

❒Academic history/honor, page 4

❒Employment/activities/community services, page 5

❒Two recommendation forms (each form must be sealed in an envelope and signed across back), pages 6 and 7

❒Essay (no more than 300 typed words, may use regular white paper), page 8

❒Report of any unusual family, personal or financial circumstances if applicable, page 9

Attachments

❒Proof of residency of town identified page 1; submit one of the following: drivers' license, passport, voter registration

❒Proof of acceptance in a nursing program (See page 3)

❒Transcript(s) - attach copy

❒College tuition and fees - attach copy

Other

❒Have not received a scholarship from this organization in the past

❒Email address: _____

CERTIFICATION SECTION

In submitting this application, I certify that the information provided is complete and accurate to the best of my knowledge. If requested, I agree to give proof of information I have given on this form. Falsification of information may result in termination of any scholarship granted. This application and attached materials become the property of Hospital for Special Care Foundation, Inc.

Applicant's Signature: _____ Date: _____

Parent/Guardian Signature:_____ Date:_____

Required *if you are claimed as a dependent on tax forms, even if you are over 18.*

Please check all that apply: ❑ High School Senior; ❑ Community member residing in the Greater New Britain area;
❑ If you are a family member of a Hospital for Special Care benefit eligible employee or volunteer, please provide family member name: _____

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ACADEMIC PROFILE

Instructions: This section must be completed and signed by an official of your school.

The GPA must be reported as its equivalent on a 4.0 scale and certified by a school official. Failure to report grade-point **average on a 4.0 scale may disqualify this application. If the school does not use GPA please provide similar information:**

Cumulative grade-point average: _____/ 4.0 scale Class rank if applicable: _____ of _____

School Official's Signature: _____ Date: _____

School Official's Title: _____ Telephone: _____

School:_____

Address: _____
Street City State Zip

Important: Enclose academic transcript from your high school, post-secondary programs, or vocational/technical schools attended.

COLLEGE/PROGRAM INFORMATION

Name of program to which you have been accepted, or enrolled, for the **2017-2018** academic year:

School:_____ City: _____ State: _____

Status for the September **2017-2018** academic year: ❑ Full-Time ❑ Part-Time

Class you will be entering in September: ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior

❑ Other/Explain: _____

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ACADEMIC HISTORY

Beginning with high school, please list all schools you have attended:

SCHOOL CITY/STATE MAJOR/SUBJECT GRADUATION DATE (mm/yy)

_____

_____

_____

_____

_____

_____

_____

ACADEMIC HONORS

List academic honors you have received during the past four years. Limit to the ten most recent.

ACADEMIC HONORS DATE RECEIVED

_____

_____

_____

_____

_____

_____

_____

_____

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EMPLOYMENT HISTORY, EXTRACURRICULAR ACTIVITIES, AWARDS, OTHER

Employment (Limit to 5; please start with most recent):
Indicate any full-time or part-time position held. Note if this was summer employment

DATES EMPLOYED | EMPLOYER | TITLE | HRS./WK.

Publications (Limit to 5; please start with most recent):

Research Projects (Limit to 5; please start with most recent):

Community Service/Awards List volunteer work or community service activities without pay begin with most recent):

ORGANIZATION | ACTIVITY/EVENT | YEAR(S) PARTICIPATED | TOTAL HOURS VOLUNTEERED

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RECOMMENDATION FORM – 1: May attach letter to this form

- To be completed by an advisor, counselor, instructor, or work supervisor.
- Recommendation forms from two separate individuals must be submitted.

Instructions for advocate/sponsor.

DO NOT include any information that would allow the selection committee to identify the applicant. Any reference to the applicant's name, parent/guardian's name, employer, or any association with the Hospital for Special Care Foundation, Inc. or the Center of Special Care, Inc. within the content of the evaluation will disqualify the application.

Please enclose the completed form in an envelope, sign your name across the seal, and return to the student.
Please do not mail this form directly to Hospital for Special Care; it must arrive with the application package to the Hospital for Special Care Foundation, Inc.

	EXCELLENT	GOOD	FAIR	POOR
The applicant's self-motivation				
The applicant's commitment to school and/or community				
The applicant's ability to seek, find and use learning resources				
The applicant's curiosity and initiative				
The applicant's problem-solving abilities				
The applicant's respect for self and others				

Please write a short evaluation of this student. Please use **black ink**, thank you.

_____
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Advocate/Sponsor's Name: _____ Title: _____

Signature: _____Telephone: _____

Business Address: _____
Street City State Zip

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RECOMMENDATION FORM - 2: May attach letter to this form

- To be completed by an advisor, counselor, instructor, or work supervisor.
- Recommendation forms from two separate individuals must be submitted.

Instructions for advocate/sponsor.

DO NOT include any information that would allow the selection committee to identify the applicant. Any reference to the applicant's name, parent/guardian's name, employer, or any association with the Hospital for Special Care Foundation, Inc. or the Center of Special Care, Inc. within the content of the evaluation will disqualify the application.

Please enclose the completed form in an envelope, sign your name across the seal, and return to the student.
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	EXCELLENT	GOOD	FAIR	POOR
The applicant's self-motivation				
The applicant's commitment to school and/or community				
The applicant's ability to seek, find and use learning resources				
The applicant's curiosity and initiative				
The applicant's problem-solving abilities				
The applicant's respect for self and others				

Please write a short evaluation of this student. Please use **black ink**, thank you.

_____
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Advocate/Sponsor's Name: _____ Title: _____

Signature: _____Telephone: _____

Business Address: _____
Street City State Zip

ESSAY FORM

Instructions:

Essay must be limited to **300 words,** typed and double-spaced, and attached to this form.

Explain your long-range goals (for school, employment, and life as you would like), and describe what experiences, skills and personal values will help you achieve those goals.

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REPORT ANY UNUSUAL FAMILY, PERSONAL, OR FINANCIAL CIRCUMSTANCES WHICH YOU BELIEVE WARRANT CONSIDERATION BY THE COMMITTEE.